The State of Delaware

Considerations for FY18 Changes

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May 8, 2017

Willis Towers Watson

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Focus areas for the Group Health Insurance Program

- Below are major areas of focus for the Group Health Insurance Program in the near-term
  - All link back to tactics within the GHIP Strategic Framework (explicitly or implicitly)
- Outside of the topics noted in the upper left quadrant ("In Process for FY18"), the remaining topics under the other major areas are *opportunities* for change which are still under review by the SBO/SEBC
  - Many opportunities are mutually exclusive, e.g., implementing an active medical enrollment does not require changing medical plan designs
  - Changes have been segmented by population where possible

In Process for FY18 (effective 7/1/17)

- Admin fee reduction
- Value-based care models
- Improved consumer decision support
- Enhanced clinical management
- US Imaging implementation

Participant Engagement in Health and Wellness

- Centers of Excellence
- Active enrollment
- Member tools
- Health incentives

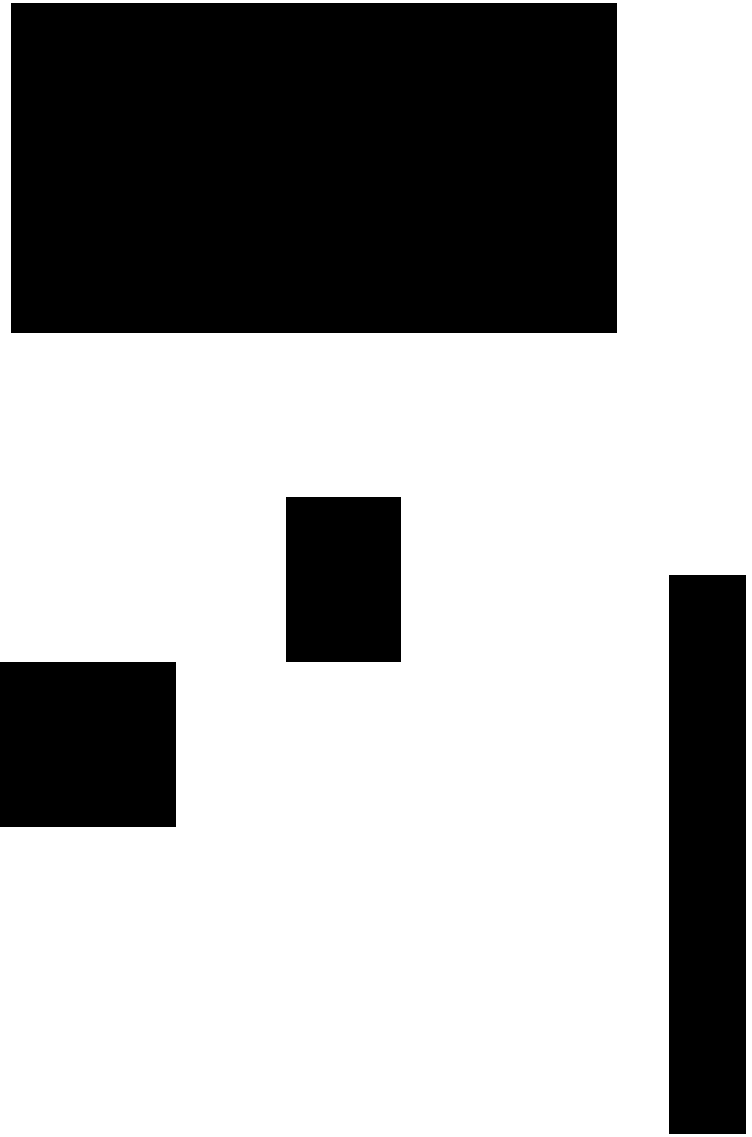
Additional Opportunities for FY18 (target 1/1/18)

- Plan design modifications
- Cost share modifications
- Special Medicfill Plan modification
- Double State Share elimination

Health Plan Task Force Report

- Review findings and recommendations
- Identify opportunities/next steps

Revisiting the State Employees Health Plan Task Force



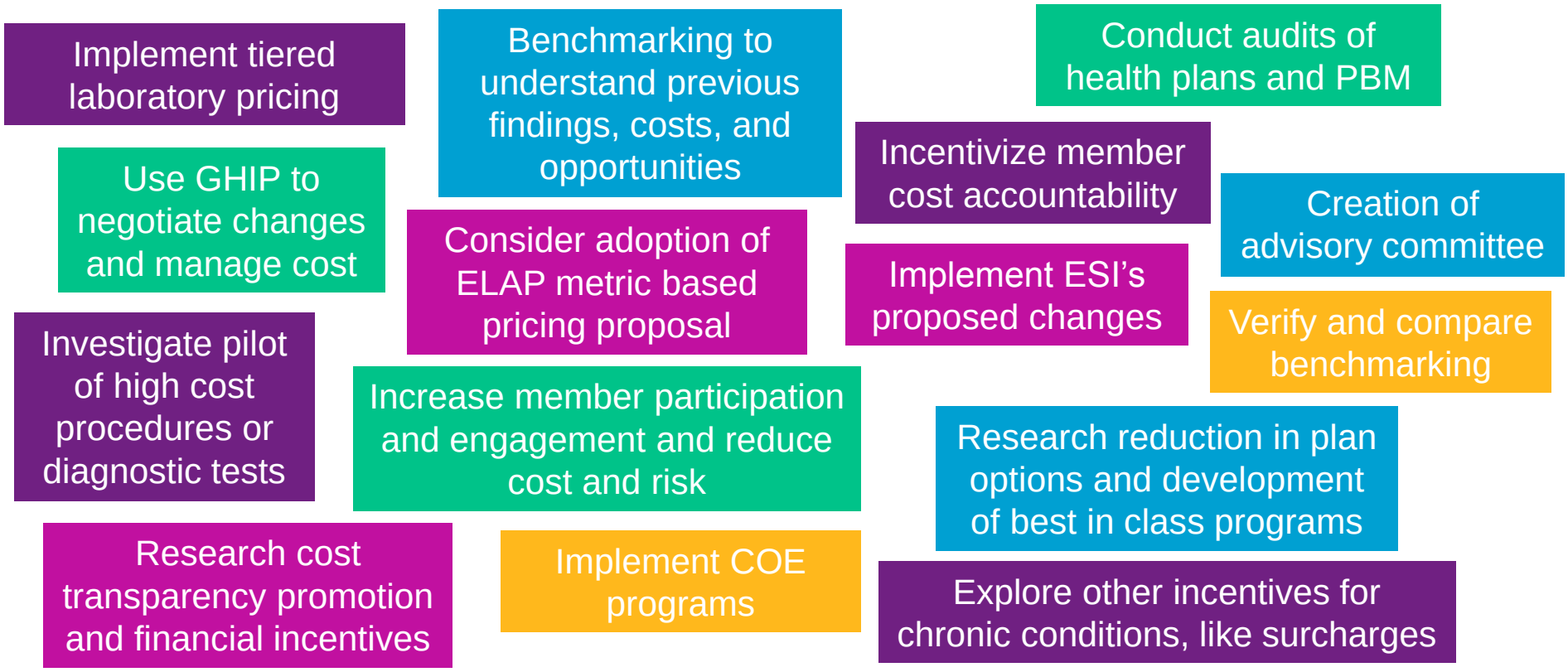
State Employees Health Plan Task Force – background and overview

- The FY16 operating budget bill included language which required the formation of the State Employees Health Plan Task Force
- The Task Force met through the fall of CY2015 and ultimately issued a report to the Governor and General Assembly on December 16, 2015
- Task Force committee members included elected and appointed officials, members of the Delaware legislative arm and members from several Delaware Associations (including State Education, State Troopers and Corrections)
- The report focused on several short-and-long term actions of considerations, segmented by the following categories:
  - Bending the cost curve
  - Exploring opportunities to realign provider payments
  - Benchmarking GHIP plans and costs on a comparable basis
  - Improving the health of the population
- The Health Plan Task Force commission and subsequent report was one of the key pieces of background used in developing the GHIP Strategic Framework (along with several other inputs, including stakeholder interviews)
- *Specific findings and recommendations, organized from the Task Force report, are included in the appendix*

State Employees Health Plan Task Force report

Summary of findings

- Highlighted below are several key findings within the Health Plan Task Force report
- Findings, while relevant, did not place emphasis on prioritization



Summarization of findings from Section V of the Health Plan Task Force Report, dated December 15, 2015

State Employees Health Plan Task Force report

Summary of findings – ***Willis Towers Watson organization of findings***

- The findings from the Health Plan Task Force report can be bucketed into two main categories: supply-related health care and demand-related health care
  - Supply-related health care: Focus on smarter production of care (i.e., network modifications, utilization of value-based care models, on-site clinics)
  - Demand-related health care: Focus on smarter consumption of care (i.e., use of consumer-driven plans, utilization of transparency tools, plan design diversity)
- Both of these categories should have the focal area changed from sickness-centric to wellness-centric

Supply
Use GHIP to negotiate changes and manage cost
Implement Center-of-Excellence programs
Implement tiered laboratory pricing
Metric-based pricing proposal

Demand
Transparency and financial incentives
Pilot of high cost procedures of diagnostic tests
Benchmarking
Incentivize member cost accountability
Increase member participation and engagement and reduce cost and risk
Validate number of plan offerings
Health plan audits
Implementation of special vendor programs

Supply
Demand

Summarization of findings from Section V of the Health Plan Task Force Report, dated December 15, 2015

Tying Health Plan Task Force to GHIP Strategic Framework

- Many findings from the Task Force report were incorporated as tactics of the GHIP Strategic Framework
  - Some tactics may be applicable to multiple findings from the Task Force Report
  - A sample of relevant tactics have been presented for each Task Force finding

	State Employees Health Plan Task Force Finding	Link to GHIP Strategic Framework		
		Goal	Timing	Tactic(s)
Supply	Use GHIP to negotiate changes and manage cost	■○	FY17-18	▪ Evaluate local provider capabilities to deliver Value-Based Care Delivery (VBCD) models via medical third party administrator (TPA) RFP ▪ Negotiate strong financial performance guarantees ▪ Select vendor(s) with most favorable provider contracting arrangements ▪ Look for leveraging opportunities with the Delaware Center for Health Innovation (DCHI) and Delaware Health Information Network (DHIN) to partner on promotion of value based networks (including All-Payer Claims Database (APCD) initiative) ▪ Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL
Supply	Implement Center-of-Excellence (COE) programs	■○	FY17-18	▪ Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP ▪ Implementation of VBCD models from medical TPA RFP (including COEs)
Supply	Implement tiered laboratory pricing	○	FY18-19	▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology Utilization Management (UM) and other medical and Rx UM programs, where necessary
Supply	Metric-based pricing proposal	○	FY17-18	▪ Senate Bill 238 was signed by Governor Markell on July 21, 2016 and establishes the Delaware Health Care Claims Database within the Delaware Health Information Network which will create greater transparency around health care costs and mandates reporting of claims data for GHIP. Regulations are currently being developed.
Demand	Transparency and financial incentives	■○▲	FY17-19	▪ Promote medical plan TPAs' provider cost/quality transparency tools ▪ Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies ▪ Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc. ▪ Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool)

GHIP Strategic Framework Goals:

■ Addition of at least net 1 VBCD model by end of FY2018 | ○ Reduction of gross GHIP trend by 2% by end of FY2020 | ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Tying Health Plan Task Force to GHIP Strategic Framework

	State Employees Health Plan Task Force Finding	Link to GHIP Strategic Framework		
		Goal	Timing	Tactic(s)
Demand	Pilot of high cost procedures of diagnostic tests	○	FY18-19	▪ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology Utilization Management (UM) and other medical and Rx UM programs, where necessary
	Benchmarking	■	FY17-19	▪ Evaluation of clinical data to implement more value-based chronic disease programs ▪ Note: Also included in the initial current state analysis conducted by WTW in CY2016 and in Truven quarterly dashboards (not captured on GHIP Strategic Framework but provided to SEBC on a regular, ongoing basis)
	Incentivize member cost accountability	○	FY17-19	▪ Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ▪ Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) ▪ Evaluate incentive opportunities through incentive-based activities and/or challenges
	Increase member participation and engagement and reduce cost and risk	■○▲	FY17-19	▪ Launch healthcare consumerism website ▪ Roll out and promote SBO consumerism class to GHIP participants ▪ Explore avenues for building "culture of health" statewide ▪ Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool) ▪ Evaluate feasibility of offering incentives for engaging in wellness activities ▪ Continue to monitor and evaluate VBCD opportunities
	Validate number of plan offerings	○▲	FY17-19	▪ Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance ▪ Change medical plan designs and employee/retiree contributions to further differentiate plan options ▪ Change the number of medical plans offered
	Health plan audits	n/a	FY19-20	▪ Ongoing at the time GHIP Strategic Framework was developed; WTW recommends conducting every 1-3 years
	Implementation of special vendor programs	○▲	FY17-19	▪ Select vendor(s) that can best manage utilization and population health ▪ Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP

*UM = Utilization Management | DM = Disease Management | CM = Case Management

GHIP Strategic Framework Goals:

■ Addition of at least net 1 VBCD model by end of FY2018 | ○ Reduction of gross GHIP trend by 2% by end of FY2020 | ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Continuation of Design and Contribution Modifications Discussion

Medicare retiree design consideration – ESI non preferred generics

- Traditional mechanisms for managing prescription drug cost and utilization in commercial populations (i.e., prior authorization, step therapy, etc.) are not available to plan sponsors with an EGWP population
- Express Scripts (ESI) has developed a new formulary tier available to the State's EGWP population for Non-Preferred Drugs (NPD)
  - Allows for greater management of both brands and high cost generics in a mechanism that has been approved by CMS
- 830 National Drug Codes approved by CMS for non-preferred drug tier
- ESI has modeled the cost impact to members (i.e., savings for the State) under several scenarios in which all or certain classes of NPD would be shifted into a non-preferred drug tier

Cost Shift to Members	Annual GHIP Savings
All Generic Drugs in NPD Tier	$152,600
Excludes Diabetes	$127,100
Diabetes Impact	$25,400

Note: Savings based on EGWP member utilization data for the time period March 1, 2016 - February 28, 2017.

Current EGWP Rx plan design vs. ESI-modeled plan design

CURRENT		Retail Range 1		Retail Range 2		Mail Range 1		Mail Range 2	
Tier Name	Tier Number	Day Supply Range	Flat	Day Supply Range	Flat	Day Supply Range	Flat	Day Supply Range	Flat
GENERIC	1	1-31	$8.00	32-90	$16.00	1-31	$8.00	32-90	$16.00
PREFERRED BRAND	2	1-31	$28.00	32-90	$56.00	1-31	$28.00	32-90	$56.00
NON PREFERRED GENERIC	1	1-31	$8.00	32-90	$16.00	1-31	$8.00	32-90	$16.00
NON-PREFERRED BRAND	3	1-31	$50.00	32-90	$100.00	1-31	$50.00	32-90	$100.00

MODELED		Retail Range 1		Retail Range 2		Mail Range 1		Mail Range 2	
Tier Name	Tier Number	Day Supply Range	Flat	Day Supply Range	Flat	Day Supply Range	Flat	Day Supply Range	Flat
GENERIC	1	1-31	$8.00	32-90	$16.00	1-31	$8.00	32-90	$16.00
PREFERRED BRAND	2	1-31	$28.00	32-90	$56.00	1-31	$28.00	32-90	$56.00
NON PREFERRED GENERIC	3	1-31	$50.00	32-90	$100.00	1-31	$50.00	32-90	$100.00
NON-PREFERRED BRAND	3	1-31	$50.00	32-90	$100.00	1-31	$50.00	32-90	$100.00

Source: Express Scripts.

ESI non preferred generics – EGWP member impact

- Below are additional details on the cost impact to members
- There are other lower cost drug options available for the affected drug classes
  - An appeal process exists for members who need to remain on a generic NPD for a medical reason, which would allow them to continue to pay for that drug at a lower generic copay

Drug Clinical Category	# Scripts Affected	% Total Scripts	# Members Affected
Skin Conditions	762	23%	496
High Blood Pressure/Heart Disease	652	20%	190
Diabetes	501	15%	166
Pain/Inflammation	446	13%	194
Skin Infections	311	9%	213
Nausea/Vomiting	163	5%	58
Mental/Neuro Disorders	139	4%	32
Parkinson's Disease	80	2%	12
Infections	60	2%	42
Attention Disorders	48	1%	11
All Other Drug Clinical Categories	165	5%	n/a
Grand Total	**3,327**	**100%**	
Unique Count of Affected Members			**1,399**
% of Total EGWP Members			**6%**

Note: EGWP member utilization data for the time period March 1, 2016 - February 28, 2017.

ESI non preferred generics – examples

- Below are examples of lower cost alternatives for non preferred generics with the highest utilization by EGWP members (i.e., either 100+ scripts or 100+ members affected)

#	Non-Preferred Generic Drug Name	Drug Clinical Category	# Scripts Affected	# Members Affected	Preferred Generic Alternative
1	Clobetasol Propionate	Skin Conditions	480	305	Clobetasol gel or spray
2	Metformin HCL	Diabetes	495	164	Metformin HCL ER
3	Econazole Nitrate	Skin Infections	220	144	Several topical antifungal options at preferred generic tier
4	Lidocaine	Pain/Inflammation	250	138	Lidocaine adhesive patch
5	Desonide	Skin Conditions	140	102	Desonide ointment 0.05% strength
6	Amlodipine/Atorvastatin	High Blood Press/Heart Disease	291	86	Separate prescriptions for Amlopdipine and Atorvastatin
7	Dronabinol	Nausea/Vomiting	163	58	Separate prescriptions for Ondansetron or Granisetron
8	Clonidine	High Blood Press/Heart Disease	131	34	Clonidine tablet
9	Amlodipine/Valsartan/ Hcthiazid	High Blood Press/Heart Disease	107	30	Separate prescriptions for Amlopdipine, Atorvastatin, & Hydrochlorothiazide
10	Donepezil HCL	Mental/Neuro Disorders	133	30	Donepezll 5mg or 10mg strength
	Subtotal - Scripts		**2,410**		
	Subtotal - Unique Count of Members			**1,057**	
	% of Total		**72%**	**76%**	

Note: EGWP member utilization data for the time period March 1, 2016 - February 28, 2017.

Highmark Delaware Diabetes Prevention Program – overview

- Highmark has developed a structured lifestyle and health behavior change diabetes prevention program ("DPP") with the goal of preventing the onset of diabetes in individuals who are pre-diabetic
  - Certified by Centers for Disease Control and Prevention (CDC)
  - Endorsed by Centers for Medicare and Medicaid Services (CMS)
- Effective 1/1/18, CMS has mandated a Diabetes Prevention Program as a covered benefit for Medicare
- Targets the pre-diabetic population
  - Goal: Lose 5% of body weight
- Can be implemented off-cycle with medical plan year (e.g., effective August 2017)

Pre-Diabetes: Clinical Profile

Body Mass Index (BMI) of 25 or greater

- Healthy Weight = BMI 18.5 to 24.9
- Overweight = BMI 25 to 29.9
- Obese = BMI >=30
- Morbidly Obese = BMI >=40

Fasting Plasma Glucose of 100-125mg/dl

- Or HbA1c of 5.7 percent to 6.4 percent, or
- Impaired Glucose Tolerance Test of 140 mg/dl-199 mg/dl

No previous diagnosis of diabetes

Diabetes Prevention Program structure

- Highmark is collaborating with two vendors to offer a solution for pre-diabetes management with the member's choice of Virtual and On-site options
  - RetroFit is the virtual vendor and YMCA is the on-site vendor
- Intent is to cover program as a Preventive Benefit, i.e., covered at 100% with no member cost share
- Members are identified by an online screening assessment on Highmark member portal
  - Broad communication campaign is key to raising member awareness
  - Members can be identified through claims data, though opportunity to do so is limited as pre-diabetes claims are not common
  - Future goal to educate providers about the program to encourage referrals of pre-diabetic members, although Highmark will inform its True Performance providers as well as those participating in the Aledade ACO
- Members who take online assessment and qualify as pre-diabetic are prompted to enroll in choice of Virtual or On-site program
- Members who either do not qualify, or qualify but are not ready to enroll, will be referred to a Highmark Health Coach and other Highmark programs, such as disease management

Diabetes Prevention Program structure

Onsite vs. virtual program options

Virtual with Retrofit

- Welcome kit with wireless scale, activity tracker that automatically feed to Retrofit dashboard
- 1:1 expert coaching sessions for nutrition, behavior change, exercise physiology
- Expert-led classes
- Expert-moderated online community (peer support)
- Online app (downloaded during online enrollment in program) and web dashboard including food, weight, and activity tracking
- Online proactive and reactive messaging
- Video (live) coaching sessions (telephonic support when preferred)
- Text messaging for “in the moment” personalized coaching
- Centers for Disease Control and Prevention (CDC) approved curriculum

On-site at the YMCA

- Member attends structured sessions at a YMCA location
- Led by a trained Lifestyle Coach
- Year-long program with 25 sessions
- Includes food, weight and activity tracking
- Peer support and accountability (on-site weight monitoring)
- Doesn’t require membership to YMCA, but some locations may offer free access to exercise classes and/or equipment
- Centers for Disease Control and Prevention (CDC) approved curriculum

Estimated annual program fees and savings

- Based on Highmark's proposed pricing, estimated participation rates and savings, WTW has estimated the range of potential costs and savings from this program
- Assumes program is offered to active employees, non-Medicare eligible retirees and their covered dependents
- Fees are based on members' progress towards goals (i.e., 5% or 9% reduction in body weight)
  - Fees based on members enrolled in the program; only members who meet pre-diabetes criteria can enroll
  - Fee varies based on option member chooses – Virtual or On-site
  - Portion of program fee will be payable regardless of whether member meets goal
  - Remainder of program fee will be payable only upon member achieving goal
- Claims are submitted by Retrofit and YMCA to Highmark for each milestone achieved

Assumptions	Range[1]
Prevalence of Pre-Diabetes	30% - 40% of total population
Highmark DPP Enrollment Rate	3% - 8% of pre-diabetics
Goal Achieved (5% Weight Loss)	50% - 60% of members enrolled in DPP
Estimated Savings per Member with 5% Weight Loss[2]	$400 - $1,300 in plan cost avoided per year

[1]Source: Highmark.
[2]CMS estimates savings for Diabetes Prevention Programs at $2,600 per year; savings range in chart above reflects estimates provided by Highmark.

	Annual Estimates	If 100% of members who enroll in the DPP choose: On-site option	Virtual option
Low end of range	Gross savings	$113,000	$113,000
	Total cost	$317,000	$249,000
	Net savings / (cost)	**($204,000)**	**($136,000)**
High end of range	Gross savings	$1,570,000	$1,570,000
	Total cost	$1,127,000	$886,000
	Net savings / (cost)	**$443,000**	**$684,000**

Estimated annual net savings/(cost) ranges from ($204,000) to $684,000

Active/Pre-65 retiree combination design/cost sharing scenarios

- The following table illustrates the FY18 State and General Fund savings associated with the following alternatives effective 1/1/18:
  - Add deductibles to the HMO and PPO plans, and
  - Increase the overall active/pre-65 retiree cost share by 1%, 2% and 3%

Deductible (single/family)	Current (10.6% Cost Share)		1% Increase (11.6% Cost Share)		2% Increase (12.6% Cost Share)		3% Increase (13.6% Cost Share)	
	State Total	General Fund[1]	State Total	General Fund[1]	State Total	General Fund[1]	State Total	General Fund[1]
Current Plan Design	$0.0 M	$0.0 M	$3.4 M	$2.2 M	$6.7 M	$4.4 M	$10.1 M	$6.5 M
$50 / $100	$1.2 M	$0.7 M	$4.4 M	$2.8 M	$7.7 M	$5.0 M	$11.1 M	$7.2 M
$100 / $200	$2.1 M	$1.4 M	$5.3 M	$3.4 M	$8.6 M	$5.6 M	$11.9 M	$7.7 M
$150 / $300	$3.2 M	$2.1 M	$6.2 M	$4.0 M	$9.5 M	$6.2 M	$12.8 M	$8.3 M
$200 / $400	$4.3 M	$2.8 M	$7.2 M	$4.7 M	$10.5 M	$6.8 M	$13.8 M	$9.0 M
$250 / $500	$5.2 M	$3.4 M	$8.0 M	$5.2 M	$11.3 M	$7.3 M	$14.6 M	$9.5 M
$500 / $1000	$9.2 M	$6.0 M	$11.6 M	$7.5 M	$14.9 M	$9.6 M	$18.1 M	$11.8 M

- Note: savings from adding deductibles are partially offset by a reduction in premium revenue since employee/pensioner contributions are a percentage of plan premium
- Expected FY18 active/pre-65 retiree premium cost share is 10.6%[2]; increases shown above moves cost sharing in the direction towards market norms

[1] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST

[2] Based on expected enrollment used to develop FY18 budget; reflects final TPA RFP decisions and anticipated migration

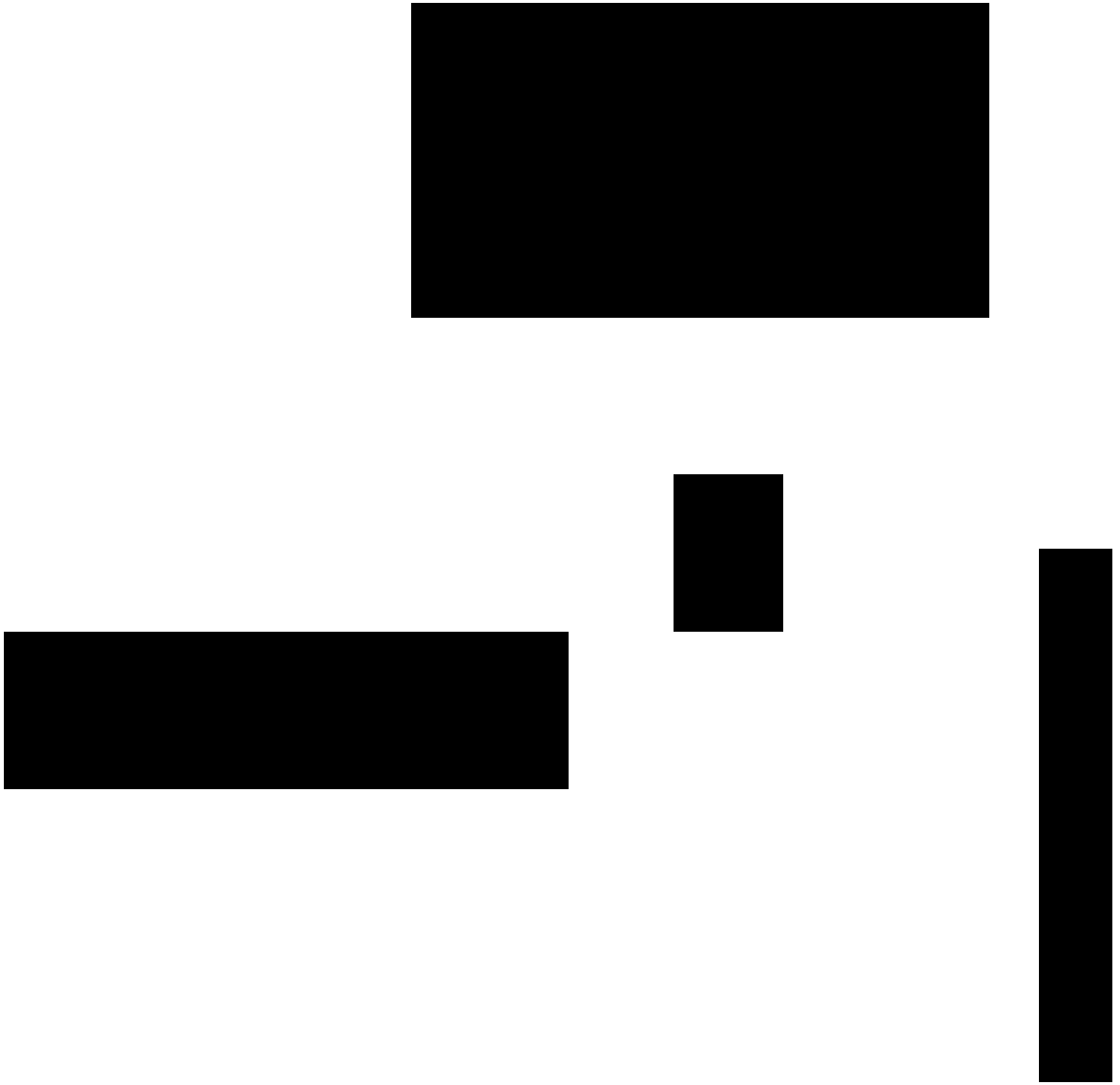
Active/Pre-65 retiree design/cost sharing scenarios – employee impact

- The table below illustrates FY18 employee/pensioner annual contribution as a percent of pay, based on current contribution levels and for each the plan design and cost sharing alternatives under consideration
  - Illustrated for sample employees earning $25,000 and $50,000 annually

Annual Payroll Contribution as % of Pay[1]	Employee earning $25,000 annually				Employee earning $50,000 annually			
	Status Quo	Cost Share Increase			Status Quo	Cost Share Increase		
		+1%	+2%	+3%		+1%	+2%	+3%
HMO - Employee Only								
Current Plan Design	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
$50 Deductible	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
$500 Deductible	2.2%	2.4%	2.7%	2.9%	1.1%	1.2%	1.3%	1.4%
HMO - Family								
Current Plan Design	6.0%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
$50 Deductible	5.9%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
$500 Deductible	5.9%	6.4%	7.0%	7.5%	2.9%	3.2%	3.5%	3.8%
PPO - Employee Only								
Current Plan Design	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
$50 Deductible	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
$500 Deductible	5.0%	5.5%	5.9%	6.4%	2.5%	2.7%	3.0%	3.2%
PPO - Family								
Current Plan Design	13.1%	14.3%	15.6%	16.8%	6.5%	7.2%	7.8%	8.4%
$50 Deductible	13.1%	14.3%	15.5%	16.8%	6.5%	7.2%	7.8%	8.4%
$500 Deductible	12.9%	14.2%	15.4%	16.6%	6.5%	7.1%	7.7%	8.3%

[1] Reflects payroll contribution only; does not reflect out-of-pocket expense.

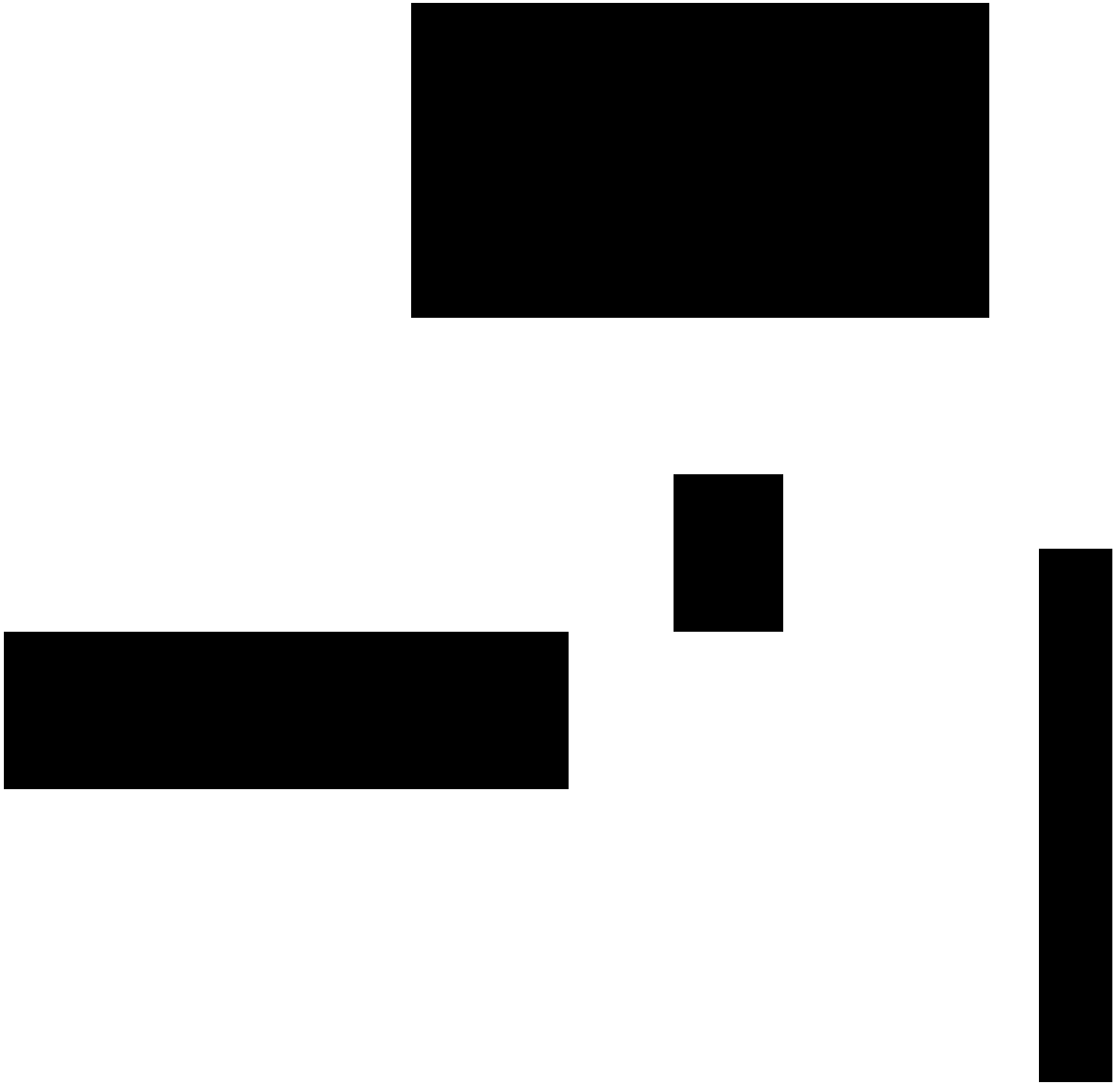
Next Steps



Next Steps

- Items to discuss at 6/26 SEBC meeting
  - Overview of FY12-FY17 annual revenues and expenditures
  - Review 3Q2017 Financial Report
  - Review April 2017 Fund Equity Report
  - Review FY18 Annualized Budget
  - Review Analysis of Responses to RFI Regarding the Feasibility for Employer-Sponsored Clinics

Appendix



Health Plan Task Force

Feedback on specific finds and recommendations

"Strategic/Long-Term Findings"

Framework	Finding	Recommendation
"Bending the Cost Curve"	Need for in depth understanding of health care delivery and payment systems through continuous research and analysis in order to make decisions that will have sustainable impact.	Creation of a comprehensive advisory committee with key members from the public and private sectors to support the legislature and the SEBC.
"Bending the Cost Curve"	Benchmarking and other data has shown that the State of Delaware's plan members, as a whole, are an increasingly unhealthy high risk population; therefore, the GHIP must focus on strategies to achieve health improvements, while managing costs.	Conduct additional comprehensive benchmarking and analysis to corroborate previous findings, estimate real cost impact per member and identify opportunities to introduce wellness and preventive programs.
"Bending the Cost Curve"	Current plan design does not promote consumerism, but at the same time does not incentivize members to seek an understanding of the cost of care.	Research methods for promoting cost transparency and consider financial incentives for members to understand the cost of care.

Health Plan Task Force

Feedback on specific finds and recommendations

"Strategic/Long-Term Findings"

Framework	Finding	Recommendation
"Payments to Providers"	Data from Highmark and Delaware based hospital leaders suggests hospital costs in Delaware are higher than for neighboring states. Additionally, Delaware's slow adoption of alternative payment options creates a cost burden to the GHIP and its members. Currently the State's hospital payment methodology is not fully available.	Use the financial impact of the GHIP on Delaware hospitals' revenue to negotiate changes and manage cost through alternative hospital payment options such as pay for performance, bundled/episodic payments and metrics-based pricing among others.
"Benchmarking"	Preliminary data indicates GHIP plans and participant contributions are richer than those offered by peer entities.	Reevaluate benchmarking ensuring the appropriate selection of peers, verification of plan values and comparability of contributions using overall compensation of state workers, which was previously outside the scope of the Task Force.
"Health Improvement"	The GHIP's increasingly high risk population and the prevalence of chronic conditions reaffirm the need of the population to understand programs and tools that support wellness and preventive services, especially as Truven reported decreases in key preventive utilization metrics regardless of financial incentives provided to members.	Explore other incentives, such as surcharges.

Health Plan Task Force

Feedback on specific finds and recommendations

"Tactical/Short-Term Findings"

Framework	Finding	Recommendation
"Bending the Cost Curve"	Abundance of plan options creates confusion among members, may result in members "over-insuring" and continued increases in trend.	Research reduction in plan options and development of best in class program with base plan and buy-up option for those members seeking additional coverage.
"Bending the Cost Curve"	ESI presented ideas on changes for managing the prescription drug programs for actives and retirees, as prescription drug trend is growing at a higher rate than medical trend.	Implement ESI's proposed changes after thorough evaluations and vetting via SEBC.
"Bending the Cost Curve"	Highmark, Aetna and public sponsored plans have successfully used Centers of Excellence (COEs) to provide savings to members and sponsors, while improving health outcomes.	Implement programs after thorough review and vetting via SEBC.
"Bending the Cost Curve"	Copayments as a cost sharing tool have not incentivized members' interest in understanding the cost of care.	Research other methods to incentivize accountability and implement tools to steer members towards more cost effective care.

Health Plan Task Force

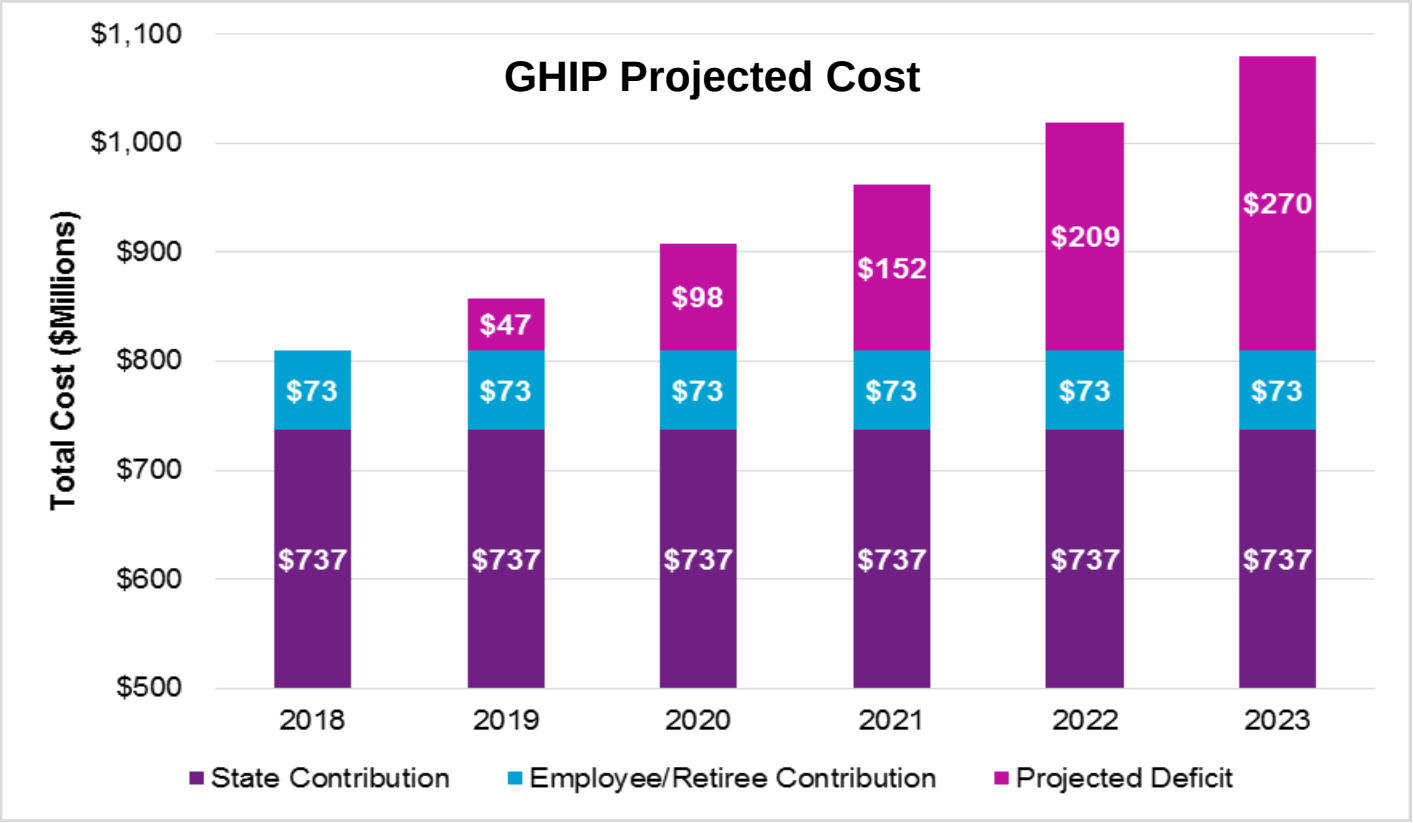
Feedback on specific finds and recommendations

"Tactical/Short-Term Findings"

Framework	Finding	Recommendation
"Payments to Providers"	Reference based pricing for elective procedures and diagnostic imaging have shown positive impact in employer sponsored plans, including public employers.	Investigate a pilot for a sample group of high cost procedures or diagnostic tests after a thorough review of all implications.
"Payments to Providers"	Adoption of tiered network pricing has shown reduction in overall laboratory spend in Highmark's insured book of business in Delaware.	Work with Highmark and Aetna to implement tiered laboratory pricing after a thorough evaluation of all implications.
"Payments to Providers"	The Task Force worked to achieve a higher level of transparency related to provider costs vs. charges, issuing RFPs to conduct audits of GHIP's health plan payments to providers.	Select a firm to conduct audits of the health plans and PBM based on RFP responses from November 2015.
"Payments to Providers"	The use of metric based pricing with hospitals has resulted in substantial savings for private and public employers according to the proposing firm ELAP.	Consider adoption of the proposal from ELAP for data collection and analysis in support of metric based pricing.
"Health Improvement"	Although the Task Force understands that chronic conditions are currently driving a significant portion of the medical and prescription drug costs, and there is general consensus regarding plan provisions and programs to improve members' health, there is no clear consensus on which programs to implement.	Explore program options for increasing participation and engagement while reducing costs and risk, including use of surcharges and financial disincentives.

Long term health care cost projections

Long-term cost projections of the Group Health Insurance Plan, at intermediate trend value of 6%, with no increase in state or employee/retiree contributions factored in for 2018 forward (assuming no program changes)



Note: FY18 budget projections assume no change to FY17 rates, and enrollment as of December 2016.
FY19 and beyond costs projected assuming 6% annual health care trend and no further program changes.

Premium cost share savings – active and pre-65 retirees

State/General Fund impact

- The following table illustrates the FY18 savings associated with 1%, 2% and 3% increases in the overall active/pre-65 retiree cost share effective 1/1/2018:

Fund Category[1]	FY18 Status Quo Contributions	1% Increase		2% Increase		3% Increase	
		Contributions	State Savings	Contributions	State Savings	Contributions	State Savings
General Fund	$47.2 M	$49.4 M	$2.2 M	$51.6 M	$4.4 M	$53.8 M	$6.6 M
Non-General Fund	$13.5 M	$14.1 M	$0.6 M	$14.8 M	$1.3 M	$15.4 M	$1.9 M
Unaffiliated	$11.0 M	$11.5 M	$0.5 M	$12.0 M	$1.0 M	$12.5 M	$1.5 M
Total GHIP	**$71.7 M**	**$75.0 M**	**$3.4 M**	**$78.4 M**	**$6.7 M**	**$81.7 M**	**$10.1 M**
Active/Pre-65 Premium Cost Share	*10.6%*	*11.6%*		*12.6%*		*13.6%*	

- Current active/pre-65 retiree premium cost share is 10.6%; increases shown above moves cost sharing in the direction towards market norms
  - 2016 Willis Towers Watson Health Care Financial Benchmarks Survey (FBS) indicates a median cost share of 22.2% for general industry and 20.0% for Education and Government/Public Sector participants

[1] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST

Premium cost share savings – active and pre-65 retirees

Employee/pensioner impact

- The following table illustrates the 1/1/2018 change in employee/pensioner contributions for each shift in active/pre-65 retiree cost share
  - Assumes a uniform increase across all plans (i.e., a 1% increase in active/pre-65 retiree cost share increases current contributions for all plans and coverage tiers by 9.4%)

Employee/Pensioner Monthly Contribution	FY18 Status Quo Contribution	+1% Increase		+2% Increase		+3% Increase	
		Contribution	$ Difference	Contribution	$ Difference	Contribution	$ Difference
First State Basic[1]	*4.00%*	*4.38%*		*4.76%*		*5.13%*	
Employee	$27.84	$30.46	$2.62	$33.07	$5.23	$35.69	$7.85
Employee & Spouse	$57.52	$62.92	$5.40	$68.33	$10.81	$73.73	$16.21
Employee & Child(ren)	$42.26	$46.23	$3.97	$50.20	$7.94	$54.17	$11.91
Family	$71.92	$78.68	$6.76	$85.44	$13.52	$92.19	$20.27
CDH Gold[1]	*5.00%*	*5.47%*		*5.94%*		*6.41%*	
Employee	$35.98	$39.36	$3.38	$42.74	$6.76	$46.12	$10.14
Employee & Spouse	$74.58	$81.59	$7.01	$88.60	$14.02	$95.60	$21.02
Employee & Child(ren)	$54.96	$60.12	$5.16	$65.29	$10.33	$70.45	$15.49
Family	$94.78	$103.69	$8.91	$112.59	$17.81	$121.50	$26.72
HMO[1]	*6.50%*	*7.11%*		*7.72%*		*8.33%*	
Employee	$47.16	$51.59	$4.43	$56.02	$8.86	$60.45	$13.29
Employee & Spouse	$99.50	$108.85	$9.35	$118.20	$18.70	$127.55	$28.05
Employee & Child(ren)	$72.18	$78.96	$6.78	$85.74	$13.56	$92.53	$20.35
Family	$124.12	$135.78	$11.66	$147.45	$23.33	$159.11	$34.99
PPO[1]	*13.25%*	*14.49%*		*15.74%*		*16.98%*	
Employee	$105.18	$115.06	$9.88	$124.95	$19.77	$134.83	$29.65
Employee & Spouse	$218.26	$238.77	$20.51	$259.28	$41.02	$279.79	$61.53
Employee & Child(ren)	$162.08	$177.31	$15.23	$192.54	$30.46	$207.77	$45.69
Family	$272.86	$298.50	$25.64	$324.14	$51.28	$349.78	$76.92

[1] Percentages shown represent the employee/pensioner share of plan premium

Plan design savings – active and pre-65 retirees

State/General Fund impact

- The following table illustrates the FY18 State and GHIP savings associated with adding deductibles to the HMO and PPO plans effective 1/1/2018:

Deductible (single/family)	FY18 Savings by Fund Category[1]							
	General Fund		Non-General Fund		Unaffiliated		Total GHIP	
	State	Total	State	Total	State	Total	State	Total
$50 / $100	$0.7 M	$0.8 M	$0.2 M	$0.2 M	$0.2 M	$0.2 M	$1.2 M	$1.3 M
$100 / $200	$1.4 M	$1.6 M	$0.4 M	$0.5 M	$0.3 M	$0.4 M	$2.1 M	$2.4 M
$150 / $300	$2.1 M	$2.3 M	$0.6 M	$0.7 M	$0.5 M	$0.6 M	$3.2 M	$3.5 M
$200 / $400	$2.8 M	$3.1 M	$0.8 M	$0.9 M	$0.7 M	$0.8 M	$4.3 M	$4.8 M
$250 / $500	$3.4 M	$3.8 M	$1.0 M	$1.1 M	$0.8 M	$0.9 M	$5.2 M	$5.8 M
$500 / $1000	$6.0 M	$6.7 M	$1.8 M	$2.0 M	$1.5 M	$1.7 M	$9.2 M	$10.3 M

Note: savings from adding deductibles are partially offset by a reduction in premium revenue since employee/pensioner contributions are a percentage of plan premium

[1] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST

Premium cost share savings – Medicfill

- Pensioners eligible for Medicare that retired prior to July 1, 2012 currently pay no premium contributions for the Medicfill plan
- The State can achieve additional savings through elimination of the contribution inequity for these members
  - This change would require these pensioners to pay a contribution equal to 5% of the Medicfill plan premium
- As of January 2017, there were 21,262 pensioners enrolled in Medicfill paying $0 in contributions
  - 19,611 enrolled in Special Medicfill with Rx
  - 1,651 enrolled in Special Medicfill with no Rx
- The following table illustrates FY18 savings for elimination of the Special Medicfill contribution inequity effective 1/1/2018:

Plan	Enrollees[1]	Monthly Contribution	FY18 Savings by Fund Category[2]			
			General	Non-General	Unaffiliated	Total GHIP
Special Medicfill with Rx	19,611	$22.96	$1.7 M	$0.8 M	$0.2 M	$2.7 M
Special Medicfill no Rx	1,651	$13.00	$0.0 M	$0.0 M	$0.0 M	$0.1 M
Total	21,262	n/a	$1.8 M	$0.8 M	$0.2 M	$2.8 M

[1] Based on January 2017 State share percentage counts provided by OMB
[2] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST.

Plan design savings – Medicfill

- Medicare retirees have minimal medical cost sharing under the current Medicfill plan
  - Most medical services are currently covered at 100%; any increases in cost sharing through deductibles or copays would create first dollar savings for the State
- The State can achieve savings through increased cost sharing for the Medicfill plan in the form of deductibles and/or copays on specific services
  - Adding deductibles to the Medicfill plan would generate savings but may create significant member disruption
  - Adding copays for specific services such as office (OV), emergency room (ER) and/or inpatient (IP) visits can also generate savings and may be more palatable for retirees
- The following table illustrates FY18 savings for various plan design alternative for the Medicfill plan effective 1/1/2018:

Plan Design	FY18 Savings by Fund Category[1]			
	General Fund	Non-General Fund	Unaffiliated	Total GHIP
$50 Deductible[2]	$0.2 M	$0.1 M	$0.0 M	$0.3 M
$250 Deductible[2]	$1.0 M	$0.4 M	$0.1 M	$1.5 M
$10 OV Copay	$1.0 M	$0.5 M	$0.1 M	$1.5 M
$150 ER Copay	$0.6 M	$0.3 M	$0.1 M	$1.0 M
$100 IP Copay[3]	$0.3 M	$0.1 M	$0.0 M	$0.5 M

[1] Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST.
[2] Illustrated deductibles are per member and apply to hospital benefits only (Part A)
[3] $100 copay per day to a maximum of $200

Multi-year framework

Goal	To prepare for 2018 and beyond (7/1/16 – 6/30/2017)	To prepare for 2019 and beyond (7/1/17 – 6/30/2018)	To prepare for 2020 and beyond (7/1/18 – 6/30/2019)
Addition of at least 1 value-based care delivery (VBCD) model by end of FY2018	★ Evaluate local provider capabilities to deliver VBCD models via medical third party administrator (TPA) RFP • State-sponsored Health Clinic Request for Information (RFI) ★ Implementation of VBCD models from RFP (including COEs) • Evaluation of clinical data to implement more value-based chronic disease programs ★ Promote medical plan TPAs' provider cost/quality transparency tools	★ Implementation of VBCD models from RFP (including COEs) • Look for leveraging opportunities with the DCHI and DHIN to partner on promotion of value based networks (including APCD initiative) • Identify opportunities to partner and encourage participation in VBCD models using outside vendors, TPAs and DelaWELL • Educate GHIP population on other provider quality tools from CMS, Health Grades, Leapfrog, etc.	• Continue to monitor and evaluate VBCD opportunities
Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020	★ Negotiate strong financial performance guarantees ★ Select vendor(s) with most favorable provider contracting arrangements ★ Select vendor(s) that can best manage utilization and population health ★ Evaluate bidder capabilities surrounding Centers of Excellence via medical TPA RFP • Educate GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) ★ Evaluate vendor capabilities surrounding UM/DM/CM* via medical TPA RFP • Evaluate feasibility of reducing plan options and/or replacing copays with coinsurance* • Educate GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Evaluate incentive opportunities through incentive-based activities and/or challenges • Change certain plan inequities, e.g., double state share and Medicfill subsidy*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Explore avenues for building "culture of health" statewide • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*	★ Explore and implement medical TPA programs, such as tiered pricing for lab services, high cost radiology UM* and other medical and Rx UM programs, where necessary • Continuation of education of GHIP members on the importance of preventive care and the State's preventive care benefits (covered at 100% in-network) • Continuation of education of GHIP members on lower cost alternatives to seek care outside of the emergency room (i.e., telemedicine, urgent care centers, retail clinics) • Continuation of the evaluation of feasibility of reducing plan options and/or replacing copays with coinsurance—based on emerging market and value-based design*
GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020	• Launch healthcare consumerism website • Roll out and promote SBO consumerism class to GHIP participants ★ Evaluate recommendations for creative ways to drive engagement and participation in consumer driven health plans via medical TPA RFP through leveraging vendor tools and technologies	• Offer a medical plan selection decision support tool (e.g., Truven's "My Benefits Mentor" tool) ★ Promote cost transparency tools available through medical TPA(s) • Evaluate feasibility of offering incentives for engaging in wellness activities	• Change medical plan designs and employee/retiree contributions to further differentiate plan options* • Change the number of medical plans offered*

*May require changes to the Delaware Code

★ Denotes activity through TPA RFP process